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# **Conflict & Health in Nepal: Action for Peace Building**

Logo  
DFID/DHSP

Logo  
GTZ/HSSP

Logo  
RHDP/SDC

**Acronyms**

<b>CPN</b>	<b>Communist Party of Nepal</b>
<b>DFID</b>	<b>Department for International Development</b>
<b>DHSP</b>	<b>District Health Strengthening Project</b>
<b>EDP</b>	<b>External Development Partners</b>
<b>GTZ</b>	<b>German Agency for Technical Co-operation</b>
<b>HSSP</b>	<b>Health Sector Support Programme</b>
<b>HA</b>	<b>Health Assistant</b>
<b>HMG(N)</b>	<b>His Majesty's Government (of Nepal)</b>
<b>ICRC</b>	<b>International Committee for the Red Cross</b>
<b>IDP</b>	<b>Internally Displaced People</b>
<b>INGO</b>	<b>International Non Government Organisation</b>
<b>INSEC</b>	<b>Informal Sector Service Centre</b>
<b>NGO</b>	<b>Non Governmental Organisation</b>
<b>RHDP</b>	<b>Rural Health Development Project</b>
<b>RNA</b>	<b>Royal Nepal Army</b>
<b>SDC</b>	<b>Swiss Agency for Development &amp; Co-operation</b>
<b>TADA</b>	<b>Terrorist and Destructive Activities Act</b>
<b>TADO</b>	<b>Terrorist and Destructive Activities Ordinance</b>
<b>TOR</b>	<b>Terms of Reference</b>
<b>UPFN</b>	<b>United People's Front of Nepal</b>
<b>VDC</b>	<b>Village Development Committee</b>
<b>WFP</b>	<b>World Food Programme</b>

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**2 December 2002  
Kathmandu**

## Executive summary

### Background to the report

The District Health Strengthening Project (funded by DFID) in partnership with the Health Sector Support Programme (GTZ) and the Rural Health Development Project (SDC) is developing strategies to deliver health system support in and around the conflict in Nepal. These strategies will work within national peace-building frameworks, highlighting the need to place human rights at the front of the aid agenda and providing an opportunity to work *in* and *around* conflict as well as *on* conflict.

There is a commitment on the part of the international community to remain engaged in rural Nepal through national development programmes. It is also common cause that development should not be abandoned in favour of humanitarian relief.<sup>1</sup> This commitment is crucially important to conflict resolution. There must be a renewed effort to ensure a humanitarian space in order that these projects can continue and develop new relationships with the communities they serve.

This report was prepared on behalf of the three partner projects, providing a shared experience and similarity of approach in the work that was being undertaken and ensuring the opportunity of collating the accumulated experiences from across the country with coverage over each of the regions. Appendix 1 contains the full particulars of the Terms of Reference.

Project partners brought together a team of external consultants to help develop support strategies to enable health workers to be operational, working within the existing legal framework of the country and to clarify the legal position for the protection of health workers. The consultants were also asked to review the situation of Internally Displaced People.

### Methodology

The consultants and two project staff members conducted field visits between 23 September and 1 October 2002. The aim of these visits was to collate first hand accounts and obtain direct evidence from health workers regarding the impact of the conflict on their work.

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<sup>1</sup> See Liz Philipson, Visiting Research Fellow, London School of Economics and Political Science, "Conflict in Nepal: Perspectives on the Maoist Movement, May 2002"

Visits were undertaken in 11 districts and covered all five regions of Nepal. Twenty-five health institutions were visited, 56 health workers were interviewed and 15 victims were interviewed. Additional meetings were held with 14 different institutions and individuals including human rights organizations, NGO's, INGO's, lawyers, diplomats, international organizations and the Security Forces.

### **Major findings**

In conflict-affected areas, it is virtually impossible for health workers to carry out their duties without harassment, intimidation and interference. In these areas there are numerous examples of interference by the Security Forces with health workers facing harassment, arrest under the Terrorist and Destructive Activities Act 2002 (TADA), searches and seizure - all of which have created anxiety and concern.

Maoists are affecting the supply of health services by intimidating and threatening health workers, but the evidence suggests that they are not necessarily seeking to destroy the structures and services.

It is evident that there is a commitment by External Development Partners to continue to fund and manage projects for the immediate future. A key role of EDP's is to highlight the ethical independence and humanitarian role of the health worker to ensure the integrity of the health service.

The importance of emphasising the humanitarian role of the health worker is particularly acute because of the lack of legal protection available. There is an inability on the part of the legal system and civil society in Nepal to provide proper remedy and a right of recourse for health workers.

Health workers and project workers want to treat and provide services to whoever is in need regardless of their affiliation, but must be more adequately supported and better protected from the interference of the parties to the conflict. There is a sustained international involvement in health projects and the health service. If further developed this involvement can lead to better protection for health workers.

There is an urgent need for clarification from the Ministry of Health regarding Directives and the Right to Treat and regarding the duties, legal responsibilities and provision of services of health workers. There is much confusion and uncertainty at field level, causing significant stress and worry.

Psychological stress is prevalent among health workers and the community as a whole. There has been little action to provide psycho-social skills training in an increasingly difficult conflict environment. Mental health must now be brought higher up the health agenda in Nepal.

There is little systematic collection of data on Internally Displaced People. There must be greater co-ordination between NGO's, INGO's and External Development Partners to collect information and develop an appropriate monitoring system.

Civil society has a key role to play in disseminating information on the impact of conflict on health services and health workers. There are advocacy opportunities through media and human rights groups, for example.

This report calls for action from Government, External Development Partners, Diplomatic and Civil Society groups to highlight the humanitarian role of the health worker in Nepal.

The chapters that follow document experiences of health workers across the country as well as highlighting the impact of the conflict on communities. There is commentary of the legal realities of those working in a conflict environment as well as recommendations (Chapter 5) in support of a peace building agenda in Nepal.

## Chapter 1: Background to the Conflict

From the inception of the Nepal communist movement in the late 1940s there has been disagreement regarding the role of armed struggle and divergences between theory and practice.<sup>2</sup> During the People's Movement in 1990 the Maoist parties did not join the alliance of leftist parties created as the United Left Front but rather formed the United People's Front of Nepal (UPFN). The UPFN rejected the November 1990 Constitution which they saw as democratically inadequate and instead demanded a constituent assembly with a view to drawing up a new Constitution and eventually the formation of a People's Republic.<sup>3</sup> The UPFN contested the 1991 election and won a small number of votes.

While there were geographical, social and economic reasons for adopting the mid west as the location to launch the 'People's War' there were also specific political reasons why the insurgency was initiated in this region. Following the 1991 elections and particularly after 1993-1994 political activists of the UPFN and other leftist parties in Rolpa and Rukum were harassed by government representatives and by the local authorities. During fieldwork conducted in the area, Karki<sup>4</sup> discovered that there was significant evidence to support the Maoists claim that they and their followers had experienced severe harassment during the early, mid 1990s, and especially following their rejection of mainstream politics.

During the next two years the Maoists extended the 'People's War' by targeting the government, the police, supporters of other parties, elected local officials and those who they identified as 'class enemies'. During this period, the insurgents captured weapons from the police, began developing guerrilla zones, boycotted local elections and forced elected officials to resign from their posts. In a number of districts, the Maoists filled the vacuum left by departed officials by creating 'People's committees'. In 1998 as Maoist activities extended further the government launched a repressive police operation named Kilo Sierra Two. The government's hard-line response plus the failure of successive governments to alleviate poverty, reduce unemployment, curb corruption, provide justice, eliminate socio-economic inequalities and deliver services particularly in rural areas played a significant role in garnering support for the Maoists and enabled them to extend their presence across the country.

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<sup>2</sup> Seddon, D. The Maoist insurgency in Nepal: revolutionary theory and practice. Paper presented to the 'Symposium on South Asia', University of East Anglia. June, 2002. p .2

<sup>3</sup> Ibid. p. 3

<sup>4</sup> Karki, A. The politics of poverty and movements from below in Nepal. Unpublished PhD thesis. University of East Anglia. 2001. p. 169

The massacre of the royal family in June 2001 undoubtedly had an impact on the Maoists plans. Lack of public support for their demand of an interim government and the establishment of a republic following the massacre; the Holeri incident in Rolpa in July 2001 when the Maoists found themselves on the brink of a confrontation with the army combined with a change of government led to a cease-fire. Two rounds of talks were held during the summer of 2001 and a third planned for later in the year. The Maoists demanded a release of prisoners and the establishment of a constituent assembly. The talks were de-railed partly by the impact of September 11<sup>th</sup> in the United States and the subsequent declaration of an international "war against terrorism", which undoubtedly encouraged the new king Gyanendra to take a harder line.<sup>5</sup> On 23 November, the Maoists broke off talks and launched a series of attacks on military and civilian targets in Dang, Surkhet, Syangja and other parts of the country. For the first time the guerrillas attacked the Royal Nepal Army.

On 26 November 2001, the Government of Nepal imposed a State of Emergency, called out the army and put into place an Ordinance granting the State wide powers to arrest people involved in "terrorist" activities. Under the Ordinance (which became an Act in the spring of 2002, the CPN (Maoist) was declared a "terrorist organization" and the insurgents labelled as "terrorists". With the instigation of the State of Emergency, some fundamental rights guaranteed in the Nepali Constitution including freedom of expression, freedom of the press, freedom of movement and assembly and the right to constitutional remedy were suspended. The Ministry of Health issued a verbal directive that health workers could not treat people involved in terrorist activities without informing the local administration or security organisations and if they did action would be taken against them. Consequently many people in rural areas avoided seeking care for wounds regardless of their origin, as they feared being labelled as Maoists.

The introduction of a State of Emergency marked the escalation of the conflict and turned it from a low-intensity conflict to a high-intensity one. Seddon<sup>6</sup> states that it is estimated that 250 people (Maoists and security personnel) were killed in the days between 23 and 26 November 2001 alone. During the first month and a half of the Emergency the Nepali human rights organisation INSEC (Informal Sector Service Centre) reported that 687 people were killed by the Security Forces, with a further 184 killed by Maoists.<sup>7</sup> In the following months, the conflict continued to escalate with the Maoists launching several large-scale attacks on the Security Forces.

In April 2002, Amnesty International<sup>8</sup> stated that according to official sources more than 3300 people had been arrested on suspicion of being members or sympathizers of the CPN (Maoist) in the first month after the State of Emergency

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<sup>5</sup> Seddon *ibid.* p. 7

<sup>6</sup> Seddon *ibid.* p. 8

<sup>7</sup> INSEC Forty-five days of State of Emergency. Informal. Vol 11, No.1 January, 2002. p. 65, 67

<sup>8</sup> Amnesty International. Nepal: a spiralling human rights crisis. April, 2002. p. 2

was declared. By the end of February 2002 the number had risen to over 5000. It is suspected that many people are being held in army camps without access to their relatives, lawyers or a doctor and very few of those arrested have been brought to court. Amnesty International has repeatedly appealed to both the Government and the Maoists, raising a number of concerns around both extra-judicial killings, and other human rights violations.

The conflict has resulted in widespread disruption throughout the country. It has had a detrimental impact on the economy, negatively affected development activities and curtailed decentralization initiatives. In July 2002, the government replaced locally elected officials with civil servants, which has slowed down the decentralization process as well as having a wide range of other negative impacts. In many conflict-affected districts health workers are the only remaining government employees as all other civil servants have left following threats by the Maoists. In some cases, health workers have also fled following intimidation. Health service structures, although not immune from disruption, have survived many of the more destructive acts perpetrated by one or other side.

After the State of Emergency lapsed in August 2002, INSEC<sup>9</sup> stated that over 4000 people had been killed during the nine months of the Emergency. Of these, the Security Forces killed 3163 and the Maoists killed 719. In the second week of September 2002 the lull in large-scale Maoists attacks, which had occurred during the monsoon, was broken when Maoists killed over 100 security personnel in two attacks. The inability to conduct elections, which had been scheduled for November 2002, created a constitutional crisis, which the King stepped into on 4 October when he dismissed the Prime Minister and the entire cabinet and took over executive power. Shortly afterwards a 'caretaker' government was put in place with promises of future elections although it is very difficult to see how these could be conducted in the foreseeable future. While the Maoists initially rejected the king's take-over, they subsequently stated that they are prepared to engage him in dialogue. It is, however, unclear as to what their next initiative will be. There is a prevailing air of uncertainty in the country combined in many areas with large-scale fear and intimidation. It is generally agreed that the conflict is unlikely to resolve in the near to medium future.

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<sup>9</sup> INSEC Report (in Nepali) 27 August, 2002

## Chapter 2: Findings from field visits

### Background

From a management perspective the Health System is well organised in theory. But its day-to-day management is exceedingly fragile and made worse by the conflict and absence of effective government control over broad swathes of the country. Extended supply lines, unreliable communication links, isolated outposts, absenteeism and a general lack of accountability render effective internal control very difficult to impose. At delivery point the health system is precarious. The fragility of the system makes it vulnerable to the slightest pressure brought to bear by shows of force, demands, threats, and physical interventions by both sides of the conflict. Appendix 3 contains the current Ministry of Health register of positions within the Health Service.

### Summary of findings

The most consistent finding identified by the field visits is that health workers in conflict-affected districts are frightened and vulnerable to intimidation from both the Security Forces and the Maoists. Health personnel are unclear of the directives under which they must work and in most cases their superiors have provided them with little clarification or guidance. They face unlawful pressure to perform tasks for which they are not qualified. They are being forced to provide treatment to Maoists and are consequently vulnerable to suspicion by the Security Forces. There have been arrests of health workers by the Security Forces and in some cases abduction by the Maoists. Their work is often disrupted; there is curtailment on their movement and those of their patients. For example, although it is technically possible to transport people requiring emergency medical care during curfew hours in reality it is very difficult to do so and this has resulted in some cases in the unnecessary death of patients under their care. Health care facilities are often insecure and health personnel have been caught in crossfire situations. They point out that there are no policies for their protection. Those who are posted outside their home areas perceive themselves to be particularly at risk. There is a general feeling of lack of institutional support and some health personnel stated that they felt that they have been left to cope with limited resources and back-up in a highly complex and dangerous situation for which they were unprepared.

To highlight the main conflict-related problems faced by health workers the following section provides brief summarised case studies based on the experiences of a range of different levels of health personnel across the country.

### **Problems Relating to the Right to Treat**

All health workers interviewed stated that they want to treat whoever is in need of health care regardless of their affiliation. They recognise their role as humanitarian workers and are very aware of their obligations to the sick and wounded. They are equally aware that in the present situation if they provide treatment to Maoists they are at risk of coming to the attention of the Security Forces and of being threatened, punished in some form or other and/or arrested. One interviewee stated: "During our medical study we took an oath to treat everyone, even our enemies. Now the government is issuing orders against medical norms and stopping us from treating people".

A health professional in another district stated: "If new faces come for treatment we have a big problem with making a decision. We feel stress. If we were authorized and protected we could give health services more comfortably. But this is not the situation. We are placed in a difficult position and are in danger from both parties".

Some health workers spoke openly about how they treat all those who consult them including Maoists. Others were less explicit but it was clear that a majority of those spoken to treat Maoists. Some health workers reported that they had provided treatment at gunpoint.

Health professionals are fearful of exercising their professional duties. Not only do opposing parties in the conflict expose them in so doing to retributive action but they are also placed in an impossible position ethically and in maintaining their statutory obligations (for example under the Health Professional Council Rules 1999 – see Appendix 2).

There are obvious consequences too in terms of their employment. Ultra vires directives from the Ministry of Health or other government bodies as discussed below places health workers in a moral dilemma – a position where they risk their livelihoods and their future employment in choosing to adhere to such directives in the face of clear ethical standards.

### **Arrests of Health Workers by the Security Forces**

Health workers are being arrested. In most cases this is because it was believed that they had provided treatment to Maoists. The Royal Nepal Army (RNA) also hold for questioning systematically and routinely those persons, including health workers, who they believe may be a potential source of intelligence. Those arrested are held incommunicado with no reasons given to the next of kin, the Ministry of Health or any other professional body.

Even where proper permission is sought to arrest and hold individuals for questioning, there is no statement of the reasons for arrest or disclosure of the evidence which leads them to believe the person is involved in activities contrary to the TADA. This makes a legal challenge to any arrest virtually impossible.

During the data gathering phase of the consultancy a health worker was interviewed who was taken out of his health post by the army and was beaten in front of the community. He was then taken forced to march with the Security Forces for a day carrying a load of between 40 and 50 kilos.

In another district the army surrounded the premises of a Health Assistant (HA). They opened his consulting room and his lab, looked at his records and went through everything in the building. He was arrested and held overnight. Three weeks later he went to his home village and during a meeting at the school was abducted by the Maoists and held for five days. He was only released following the intervention of local human rights activists.

In conflict-affected districts staff are reluctant to undertake field travel, as they are vulnerable to intimidation by both sides. Consequently, many supervisory activities and outreach programmes have been severally affected. Health personnel are particularly vulnerable when transporting drugs and medical supplies. In conflict-affected areas the transportation of medications involves delays and requires lengthy coordination and negotiation with the Security Forces followed by a journey interrupted by numerous security check-points as well as the risk of encountering Maoists with whom the transporters must also negotiate. Porters who carry medicines are now often reluctant to do so as they are liable to harassment by the Security forces and are also worried that they will not be paid if the medicines are confiscated by the Security Forces or taken by the Maoists. In the course of security checks the Security Forces often insist on opening packages containing medicines and sometimes seize drugs, dressings and bandages.

In some cases the Security Forces have commandeered health service vehicles to transport military personnel that have not been returned.

### **Abduction of Health Workers by the Maoists**

Several incidents concerning the abduction of health workers by the Maoists were reported.

In one district an Assistant Health Worker was abducted by Maoists to provide medical treatment. Some members of the group who abducted him were arrested shortly afterwards and admitted that they had abducted him to provide treatment. His present whereabouts remains unclear.

## **Unlawful Pressure**

Team members interviewed a Health Assistant who was forced to conduct four post mortems. As a Health Assistant it is not within his legal remit to undertake post mortems. In each case he was required to report that the people examined had died from natural causes although this was not necessarily the case.

## **Intimidation by Both Sides**

Health workers are regularly intimidated and threatened by both the Maoists and the Security Forces.

In one district Maoists painted slogans on the wall of a sub Health Post. The next day the Security Forces arrived and told the In-charge to remove the slogans and so he re-painted the wall. The following day the Maoists returned, re-painted the slogans and told him that if he removed them they would kill him. The following day the army returned and told him to re-paint the wall. The wall was re-painted and the In-charge left for the district headquarters and has not returned to his post.

As part of the Maoist “Step Up Campaign” a Health Assistant in another district was compelled to participate in a three-day orientation program, enrolled in the “Intellectual committee” and told that in the future he must participate in Militia training. In addition to his usual duties for HMG Nepal he has to provide parallel services and must train five Assistant Health Worker’s – one from each ward of the village - within five months. When the training is finished the health workers are to start mobile health camps. This interviewee stated that he is working “according to their [Maoist] norms and guidance because no district supervisors come to the Health Post to monitor the programme”.

## **Fear**

During field visits the team met and interviewed many frightened health workers.

In one health facility team members interviewed a doctor whose institution was caught in the crossfire when soldiers shot at Maoists who were hiding behind the clinic. Bullets hit the health facility and the doctor is now so frightened that he no longer lives in his quarters but rather moves regularly from one place to another to sleep.

In a sub health post team members met a frightened out-of-district In-charge whose health post is attached to the Village Development Committee (VDC) building that had been burnt. While the health post had not been burnt a cupboard containing drugs and essential equipment was destroyed as it was positioned against a dividing wall. Neither the drugs nor the equipment have been replaced and as locals have become dissatisfied with the quality of service

the health workers feel that they are likely to be targeted by the insurgents for not doing their job properly.

A Village Health Worker in another district stated that he no longer conducts home visits as he is very frightened of meeting the Army with whom he stated it is impossible to dialogue. Health workers in a different facility reported that soldiers sometimes request medication and while they speak politely within the health post they verbally abuse the health workers outside it.

Health professionals reported that the freedom of movement of people in the communities they serve is drastically reduced and so they are less likely to come for treatment especially if it involves travelling, as they fear that they may encounter the Security Forces or be ambushed by the Maoists en route. If a medical emergency happens at night people are too frightened to seek treatment and the health workers too frightened to provide it. In one case an interviewee reported that a person who was seriously injured after a fall from a tree could not be transported to the district headquarters at night and so died. Subsequently, his relatives blamed the health workers for his death.

People with a range of traumatic-type injuries (such as those with multiple injuries caused by falls from trees and cliffs and those with large cuts and wounds) are often too frightened to seek care as they feel that if they do they may be reported to the Security Forces as suspected Maoists. One interviewee reported that the Security Forces arrested a badly injured eight year old boy that he had referred to hospital in the district headquarters as they suspected that his injuries obtained when he fell from a tree had been caused by a bomb. Subsequently, the Army visited the health facility and questioned the staff as to why they had not reported the injury. Despite the fact that the injury was not conflict-related the staff were pressurised to provide further details and warned that in future if they did not give information they would be "... responsible for what happens". This situation made the staff: "Afraid and very careful about treating people".

### **Structure and Location**

Health facilities are frequently located in unsafe settings with little attention given to the safety of health workers or to that of their patients.

Staff in health facilities that are attached to VDC's expressed particular fears and concerns about their security. In other cases we spoke to people whose institutions are located close to army barracks which places them and their patients at particular risk of being caught in the crossfire.

## **Coping Strategies**

### **Silence**

Health workers primary coping strategy is silence. They are not reporting the treatment of Maoists, nor are they registering their treatment of Maoists or are registering them under false names. As one interviewee stated “We just ignore who they are and treat them as patients”.

Health workers are constantly vulnerable to suspicion by either side. They are working in situations where there is no trust and they are getting little or no support from their management structures. Many of the complex experiences that they encounter are not reported to supervisors for fear of recrimination.

### **Negotiating with Maoists**

It is clear that many health workers negotiate with Maoists.

Staff from an INGO stated that their workers frequently meet and negotiate with the insurgents when they transport drugs and medical equipment. To date they have not been forced to hand over any supplies and in fact the Maoists at public meetings have praised their work. Recently, they have been told that they must post their planned programmes ahead of time so that the Maoists can make decisions concerning their acceptability. Staff at other projects also stated that they must seek approval before they run programmes and some reported that they have had supplies and equipment taken by the Maoists. Maoists frequently attend training sessions as part of an evaluation strategy and in some cases request to speak and when given the opportunity either comment on the programme or propagandise. In some cases interviewees reported that negotiations were unsuccessful as the Maoists decided that they would not permit planned activities to take place. The reasons for refusal are neither always clear nor stated but are usually related to Maoist perceptions of the value of a particular service. Health personnel who are well known and respected by the community are often able to continue their work.

In some districts health workers who run private clinics have to pay the Maoists a percentage of their earnings. Health workers are frequently required to make ‘donations’ to the Maoists.

As a consequence of Maoist surveillance (as well as a government directive disallowing health workers from being away from their posts for more than five days) health facilities in some rural areas are open more regularly and better staffed than previously. On the other hand due to high levels of intimidation there are significant numbers of facilities that have little or no staff other than the lowest level of health service providers. In some health posts the only employee

present is the peon who although not officially a health worker often takes responsibility for the provision of services.

## **Patterns**

Health workers in all regions of the country and at all levels of expertise are currently facing unacceptable pressures. They are working in conditions of fear, suspicion and mistrust. They are uncertain of the directives under which they are obliged to work and are being intimidated and victimized by both sides. They are being beaten, arrested and abducted.

Health workers in Nepal have lost the right to provide treatment to the sick and wounded and not to be penalized for doing so. An interviewee summed up the predicament that he and his colleagues are in by stating that patients complain about the quality of health services. Maoists complain and target health workers if they do not receive treatment. The Army complains and takes action if they do treat Maoists and if they don't inform that they have treated them.

## **Ministry of Health Directive Relating to the Treatment of Trauma**

On 1 December 2001, The Kathmandu Post<sup>10</sup> reported that the Ministry of Health had issued a directive the previous day, which warned "... medics not to treat the wounded terrorists unless ... permission [is] granted by the security authorities. The newspaper explained that at a programme organised in the capital, Health Minister Sharat Singh Bhandari, stated that,

"The doctors working both in the government hospitals and private health institutions are liable to the government action if they treat the terrorists without getting permission from the security wings. If any doctor defies it, actions will be taken against him/her as per the recently promulgated Ordinance [TADO] against the terrorists".

The same day The Rising Nepal<sup>11</sup> printed a similar but somewhat longer summary of the directive, which noted that the Ministry would take "... strong legal action against any personnel found supporting or helping destructive activities or involving in terrorist activities." And "All health workers working under the Ministry [are] to be present at their respective offices in time and provide health services to the people" Whereas The Kathmandu Post reported that the Ministry of Health directive noted that permission had to be taken before treating terrorists The Rising Nepal statement was worded slightly differently and the emphasis was on "informing" rather than "taking permission". It stated that "... if someone or [an] institution is found treating such individuals without informing the

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<sup>10</sup> Anon. Government warning to medics. The Kathmandu Post. Kathmandu. December 1, 2001.

<sup>11</sup> Anon. The Rising Nepal. Kathmandu. December 1, 2001.

local administration or security bodies, action will be taken against him/her or such institution”.

The information contained in the above directive<sup>12</sup> was also broadcasted by radio. Many health workers interviewed during the field trips stated that at no time were they given this information in writing but rather heard about the new guidelines under which they had to work via the radio. In one district health professionals stated that they had received a written directive from the District Health Office regarding treatment but were unable to locate it when requested. Interviewees in a health post in another district stated that the only directive that they had received concerned the fact that they cannot be away from their posts for more than five days. When questioned they admitted that they had heard on the radio that they had to report the treatment of Maoists to the Security Forces. Some interviewees stated that they believed that they had to first seek permission to treat Maoists whereas others stated that they could treat but must inform afterwards.

As Sharma, Osti and Sharma<sup>13</sup> note “The directive violates international ethical standards set by the World Medical Association”. They continue, “Despite attracting the attention of international medical and human rights organisations such as the American Medical Association and Amnesty International, the Ministry of Health has never retracted the directive”.

Others take a different view and state that the directive has been retracted. However, no public announcement to this effect has ever been made.

In March 2002 the Ministry of Health formed a 16-member health management committee that aimed to ensure prompt health care during the State of Emergency. Stevenson<sup>14</sup> states that this

“... committee has issued a directive, which requires that the necessary treatment be given at the earliest possible opportunity to anybody who approaches a health centre after being injured and that the patient must be treated immediately without inquiring where and how he or she was wounded or fell sick”.

Stevenson goes on to note “The directive does not specify any action that might be taken after treatment has been given and doctors [and other health workers] are still required to report patients’ details”.

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<sup>12</sup> An additional written directive requesting health institutions to keep a record of trauma cases was released at approximately the same time (see Appendix XX).

<sup>13</sup> Sharma, G, Osti, B. & B. Sharma. Physicians persecuted for ethical practice in Nepal. *The Lancet*. Vol. 359. April 27, 2002, p. 1519.

<sup>14</sup> Stevenson, P. High-risk medical care in war-torn Nepal. *The Lancet*. Vol. 359. April 27, 2002, p. 1495.

To health workers, members of the public and the Security Forces the exact status of the directive is largely irrelevant. What is important is that it is believed to be operational and as such it has had serious consequences for large numbers of people. Members of the public are often too frightened to seek medical care, as they fear that they will come to the attention of the Security Forces who will suspect them of being Maoists. Health workers are unclear of what exactly the directive requires of them and in most cases they have received no communication, clarification or support from their superiors regarding the directive or its implications for practice.

As the case studies highlight health workers have good reason to fear that they will be punished for treating Maoists without obtaining permission (and/or informing). The fact that they might have been forced by the insurgents to provide treatment and threatened with death if they report is considered irrelevant. Furthermore, health workers are at risk of intimidation or punishment if the Security Forces think that they have treated an insurgent regardless of whether they have or not and regardless of the circumstances.

## Chapter 3: Impact of the conflict

### Internally displaced people

There is evidence that large numbers of people are moving from rural conflict-affected areas to urban centres and areas perceived to be safe. Relocation for some is on a temporary short-term basis but for others it is a permanent move. It is very difficult to ascertain the full extent of the problem as there appears to be no comprehensive documentation or monitoring of people displaced by the conflict. The official statistics that do exist are linked to the provision for the victims of Maoists and therefore only people who feel confident with the Government administration seek assistance. Many development partners are aware of and concerned about the conflict-related displacement of people.

Findings from discussions with displaced people, HMG administration, development practitioners and development agency managers identified the following categories of people:

**Young people** - male and female – fear intimidation and forced recruitment by Maoists as well as retributive action by the Security Forces who might view them as providing shelter or support for Maoists moving through the affected areas. They leave their rural areas for the relative safety of build up areas and local towns. By doing so they place an added stress on already hard pressed communities who are struggling to maintain supplies of basic essentials and on the local health services. A local NGO in Nepalgunj, supported by other informants, is concerned that displaced young women are being involved in commercial sex work. As there are no other opportunities for female employment it is a matter of sex for survival. It is also reported that there has been a considerable increase in the number of young male rickshaw drivers in Nepalgunj some of whom are unable to make an adequate income.

**Migrant workers:** there is a long tradition of people - men in particular - moving for seasonal employment. This group is thought to have substantially increased; however, obtaining accurate information is almost impossible. Patterns seem to be changing as more people relocate for employment and do not return home. An additional concern raised by interviewees was that money previously sent to rural areas could no longer be remitted because of the security situation. Migrant Workers travel to border areas in an attempt to find a way of entering India. Their presence in these regions adds to the predicament faced by health workers already stymied by restrictions imposed by the Security Forces and the Maoists. Those who succeed in crossing the border are vulnerable to falling prey to unscrupulous people traffickers. Those expelled or unsuccessful in their bid to relocate to India settle in the border regions and renew their efforts to migrate.

**Victims of the Maoists and the Security forces** – This is largely a hidden group of people who live in great fear. People who register as being displaced with the Government administration are victims of the Maoists, however, due to high levels of fear not all members of this group register. There is no registration provision for people who are the victims of the Security Forces. It is impossible to estimate the numbers of people who have been the victims of torture and/or live with the continual fear of death. Small groups of people have been identified either through lawyers/human rights activists following up on known incidents or a project who has gone out to find victims. Trying to identify victims is an extremely difficult task as because of their high level of fear they are almost invisible. During the fieldtrips team members met some Maoist victims living in terror in their new environment as the Maoists continue to stalk them and to send threats to them via family members or friends who remain in their home area. Displaced people have difficulties providing for their basic survival. The few who register with the Government receive small amounts of money for a short time. When this money is no longer available extreme difficulties arise as the following case studies illustrate;

- *An elderly couple who fled their village due to Maoist activities lived for a period of time in the District headquarters. When they had used up their limited resources and no further Government support was available they faced the reality of hunger. Rather than starve they decided to return to their village and live in fear of the Maoists.*
- *A family with four teenage children left their home hurriedly due to Maoist terror. The three younger children have been unable to continue their education since moving to the District headquarters as financially it is not possible. The family's situation became so desperate that the two younger daughters began working in a teashop which provided them with food and enough money to buy supplies for the rest of the family. While working in this business the girls became involved in commercial sex work. Their clients are members of the Security Forces. After their parents discovered their new activities the family became more desperate and the father is now threatening suicide.*

Many displaced people are reported to be living with family members. This increased economic burden is adding pressures to the well being of members of extended families. Many people are feeling pressurised and find it difficult to cope and consequently the existing support systems are breaking down.

## **Mental Health**

The World Health Organisation in its annual report (2001)<sup>15</sup> recognises that mental health disorders have a negative effect on individuals, families and communities and have high costs in human, social and economic terms. The

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<sup>15</sup> The World Health Report. Mental health: new understanding, new hope. 2001

widespread disruption of everyday life associated with conflict which includes the break-up of families, the displacement of people, the loss of loved ones and the disruption of social and economic institutions leads to a range of problems that affect mental well-being.<sup>16</sup> The patterns of distress experienced by survivors of prolonged civil conflicts - which frequently take the form of generalised but pervasive fear and anxiety - often, have a severe and long-lasting impact.<sup>17</sup> It is therefore highly significant that during the fieldtrips mental health problems emerged as a growing concern right across Nepal.

Health workers emphasised that there is a need for more attention to be paid to mental health issues as people, particularly in rural areas, are experiencing high levels of fear, anxiety, sleep disorders, nightmares and a range of other psychological problems. Some health workers reported that the consumption of alcohol and tobacco has risen significantly in their communities. Most health workers reported that members of the public do not seek treatment for mental health problems. This is primarily due to the fact that the majority of the population does not know that assistance is available for psychological distress rather than an absence of these problems. Lack of awareness is compounded by the fact that the numbers of health workers trained to address mental health problems is small and so in many areas the resources are not available even if people wished to obtain them. The Nepal Government's mental health service provision is limited and available only in a few urban locations.

There are increasing numbers of people who have been directly exposed to violence and are in urgent need of assistance for the effects of brutal attacks, or who have witnessed brutal attacks (often on their loved ones), as well as those who require assistance to recover from the impact of long-term imprisonment and the effects of torture. During field trips team members met a psychiatrist who is based in a regional hospital. In the last year as the conflict has escalated this interviewee has seen a rapid increase in patients with conflict-related mental health problems. In particular he treats those who have experienced violence to themselves or their loved one, spouses and parents of the Security Forces who live in daily fear of the death of their spouses/sons and those who are unable to cope with living in continual fear. This interviewee strongly regretted the lack of attention being paid to this dimension of the conflict and emphasised the need for urgent resources to be deployed to assist people cope and recover from the impact of violence. He added, "It is now a matter of urgency as otherwise there will be large numbers of people in our country suffering from psychological problems. I fear greatly for the future mental health of our population".

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<sup>16</sup> Desjarlais, R., Eisenberg, L., Good, B., & A. Kleinman (eds) *World mental health: problems and priorities in developing countries*. Oxford University Press, 1995. p. 116

<sup>17</sup> Ibid

## Chapter 4: The legal background

It has been a unique feature of this particular consultancy that, in assisting the development of a framework in which health programmes can adapt to the current conflict, the legal scenario should be examined. An analysis of the wider legal scenario both nationally and internationally and the implications for civil society in Nepal appears in Appendix 2 of this report.

While the law technically might afford a degree of protection to health workers it does not do so in reality.

In theory the law impacts on health workers in a number of ways:

- the professional status, qualifications, positions, employment, and professional rights and obligations of health professionals are statutorily defined
- these statutorily defined obligations provide health professionals with necessary protection in the conduct of their work particularly in the treatment of wounded casualties of the conflict
- in carrying out their professional duties local health workers are placed in a very vulnerable position under the Terrorist and Destructive Activities Act 2002 (TADA)
- human rights legislation enshrined in the Constitution is ostensibly designed to protect all citizens from arbitrary and unlawful conduct of the state
- protection for humanitarian roles in the conflict are derived from international treaty obligations and incorporated into Nepali law

In formulating strategies, however, and in particular those involving the government or the security forces, it is important to emphasise the fact that international humanitarian law protects civilians caught in the cross-fire even though it might be viewed as an internal conflict. International humanitarian law, deriving its status from international instruments and obligations, more so than ever before with the development of international criminal tribunals, can intervene to protect civilians in a complementary manner to the protections afforded by human rights law. For a more detailed analysis see Appendix 2.

On the basis that certain health workers in Nepal have a statutory recognition a degree of legal protection is derived for the myriad health activities undertaken. The legal framework also imposes statutory professional obligations through the professional associations and the Health Professionals Council. In addition, the rights of individuals are protected by constitutional incorporation of international fundamental human rights provisions. Whereas the passing of legislation meant to deal with the conflict is both draconian and restrictive, seeking as it does to proscribe many of these fundamental rights, on a proper analysis the protections for the kind of activities that health workers have to engage remain, theoretically

at least, intact. International Treaty obligations as incorporated into the law of Nepal by statutory provision support such protections.

For the reasons advanced in greater detail in the appendix the legal system, in terms of structure, procedure and accessibility, cannot provide sufficient or adequate protection to health workers. Health workers are often far removed from judicial centres and with no recourse to the justice system as it exists. The inability of the justice system to provide the necessary protections is compounded by:

- the marked reluctance of the individual to engage the justice system primarily because of the lack of faith in the legal professions and the judiciary.
- Misconceptions, misinterpretations and misunderstandings of the law in general

As can be readily understood from the documented findings of the field trips local health workers generally are afforded little if any protection by the legal system against abuses from all sides in this conflict. Of particular concern is their treatment at the hands of and the abuses perpetrated by the security forces and other organs of state. Some of this conduct is deliberately targeted, calculated and premeditated. Some is derived from the sheer indifference and lack of foresight, negligence and ignorance on the part of the authorities concerned. Little, if any, regard is had to the law and the legal rights and responsibilities of the individuals as health professionals and as ordinary citizens. Even less opportunity appears to be afforded to those health workers who are victims of such abuses in terms of right of recourse to law and the justice system.

The Ministry of Health has issued directives requiring health institutions to record details of all trauma patients and a specific directive from the Minister in December 2001 to all health professionals to the effect that all such professionals seek permission prior to treating patients from the Ministry of Health. In doing so this demonstrates the singular lack of understanding by Government (either deliberate or through sheer incompetence) of the law and the legal obligations and responsibilities of health professionals. The fact that such a directive was ultra vires and with no effect in law was probably lost on many health workers who are, on the evidence of the field trip findings, still affected by it. There had been no retraction or explanation of the supposed directive. It is inconceivable that if the advice of the Government Law Officers (the Attorney General) had been sought or if the proposed directives had been tested before the senior judiciary such a fundamental undermining of the health workers in their precarious posts and positions in the field would have been undertaken.

## Chapter 5: Recommendations

### Introduction

There is an urgent need for the government and the development community to “step out of the development box” and engage with the wider community. A strategy to broaden contact with civil society, security forces and the opposing factions in the conflict will permit a more responsive and effective way of conducting longer-term project activities.

It follows that a more “hands-on” approach to project work should be viewed as essential. In advocacy terms the voice of the international community will always be heard. There may well come a time when this will change but not before circumstances are such that civil society in Nepal will be viewed as impartial and not subject to corruption.

Suggestions for district and central level action on the basis of the evidence collected in this report are now made for Government, External Development Partners, Civil Society and the Diplomatic Community.

### Health Service Delivery in districts and below

There is an immediate need to support health workers and project staff alike through a number of skills development programmes. Specifically through:

- Negotiation skills training for health workers and support staff which builds on and develops pre-existing skills (for example, what to do in the event of a threat)
- Developing health worker skills on good practice in a conflict environment through training on transparency, predictability, good governance, do no harm, and use of public audits

Health workers should be encouraged to develop their own personal security systems. For example, who/where to inform in the case of arrest or abduction (family, colleagues, friends, *Aaphno Manche*, *Thulo Manche* networks, professional organisations, people who will if appropriate contact international organisations).

Projects and the donor community should support the development of a district and national information system regarding the targeting of health workers. Liaison will take place as appropriate with the diplomatic community and/or international organisations (for example, Physicians for Human Rights, Doctors without Borders etc.)

Projects can mobilise Health Professional Organisations and ethical bodies regarding the duties and legal responsibilities of health workers through briefings and orientation programmes.

### **Health Service Delivery and Central responsibility**

A closer direct rapport between EDP representatives and ministries and departments of government should be attempted with the view to creating a forum for discussion, raising concerns, advising and ensuring compliance and implementation. A regular coordination meeting between EDP representatives and government officials representing not only the Ministry of Health but also the Law Officers (the Attorney-General), the National Human Rights Committee and other relevant NGO's.

EDP's at different levels must seek clarification from the Ministry of Health and other relevant Government bodies for clarification on two specific issues to respond to the current situation:

- Clarification from the Ministry of Health regarding Directives and the Right to Treat
- Clarification from the Ministry of Health regarding the duties, legal responsibilities and provision of services of health workers

A clearer picture on Internally Displaced People needs to be developed. While there is much evidence across the country of movement of people, there is little systematic information to make balanced judgements. Through their existing projects, EDPs can begin to develop:

- Increased and systematic collection of information about IDP's
- Co-ordination between NGO's, INGO's and Donor's must be established
- Improved co-ordination together with information collection will provide an IDP monitoring system. This will contribute to the assessment if and when humanitarian supports are necessary
- Development of economic/income generating activities for IDPs

Mental Health is clearly highlighted as a new and complex area that needs attention. There are a number of suggestions which require further analysis and review:

- Develop programmes to address specific mental health concerns (small scale and locally appropriate)
- Monitor national mental well being as part of national economic development monitoring
- Orientation on mental health to development practitioners and managers to inform development strategies in conflict

- Support HMG to reform and develop national mental health services
- Train greater numbers of health workers in the identification, treatment and referral of mental health problems

### ***Civil Society***

The development of a website notice board might be a vehicle for sharing much information on health and conflict. To ensure confidences and the efficient management of a website a coordinating group, made up of representatives of interested organisations, should be responsible for management of the website, coordination of databases, dissemination of information and security implementations.

Locally and internationally the humanitarian role and impartial nature of the work of health professionals should be widely publicised particularly to those directly involved in the conflict – from the combatants to those in command. Linking with projects that might provide a suitable vehicle for disseminating the message would provide a backdrop against which both sides of the conflict and citizens in remote areas of the country might better understand the role of health workers. Potential projects might include existing or future public health campaigns (such as Polio Vaccination), peace-building programs, projects facilitating the development of independent radio and other public media serves.

Through appropriate channels, such as Human Rights Groups and political affiliates, direct dialogue with the Maoist leadership should be encouraged in order to address the issues affecting health workers and ensure an understanding and respect for health workers, their work and their unique predicament.

### ***Diplomatic Community***

In order to achieve a settlement of the conflict Nepali society will require a radical reorganization of its primary institutions, models of governance and relationships between citizenry and the government. It will only be achieved by a systematic change – quick fixes will no longer work. There is considerable scope for promotion, encouragement, support and involvement in such a facilitation process.

A closer, more focussed involvement of the diplomatic community associated with the development community should be established. The humanitarian nature of the projects should be on the agenda of any diplomatic initiatives and discussions with parties to the conflict and commercial contacts with the State. To ensure this projects should be able to channel the necessary reliable information systematically to readily identifiable counterparts in the diplomatic community who would then be able to process the data and build up a body of information readily available in the course of diplomatic discussions.

Through diplomatic channels and initiatives the development community should be prepared to involve itself in regular dialogue with the army, the armed police and other organs of state security. The aim of such endeavours is to secure for the security forces an understanding of the role of health workers and project staff and their better protection from abuses. It also provides an opportunity for building a rapport with de facto command structures in the areas of most intense conflict. Building trust in this way might allow channels of communications, which will ultimately save health workers and project staff lives and protect them from abuses.

## **Terms of Reference Conflict and health- developing a strategy**

### **Background**

In the next year the District Health Strengthening Project (funded by DFID) will co-ordinate with the Health Sector Support Programme (GTZ) and the Rural Health Development Project (SDC) on developing strategies to deliver health system support in and around the conflict in Nepal. Working together provides the opportunity to work in 10 districts countrywide covering each of the regions. Additionally, given the sensitivity of the proposed activities this collaborative work provides strength in terms of donor and diplomatic voices.

DHSP will hire a team of 2 international consultants and 1 local consultant to develop an appropriate framework to adapt health programmes to the current conflict, which will:

- Build on the existing information about the experiences of local level health workers
- Identify support strategies to enable health workers to be operational, working within the existing legal framework of the country
- Help external development partners assess the kind of personnel required to support to the health system
- Bring clarity on the legal position for the protection of health workers in particular local health workers.
- Contribute to the ongoing work of the monitoring and assessment of internally displaced people; for example by developing simple sets of questions for field officers to ask, and record answers to
- Identify IDP advocacy options
- Identify steps to prepare the way for humanitarian assistance

### **Conflict and Health**

Conflict and health brings with it a range of complex and inter linked issues. Central is the question of health workers neutrality to provide health services balanced along side peace building activities, which may be perceived as political. This is intrinsically linked is the issue of human rights.

Rights and health

“Human rights provide a standard against which to evaluate existing health policies and programmes, including highlighting the differential treatment of individual groups of people.....Human rights norms and standards also form a strong basis for health systems to prioritise the health needs of vulnerable and marginalised population groups” p.20

“The large and changing nature of emergencies and conflicts,.....has promoted the need for new thinking and approaches” p.27

Health and Human Rights Publication Series, No 1, WHO,

Adopting different thinking and approaches is essential to respond to the current constantly changing conflict situation. What activities can be implemented and what staff skills are necessary to enable this to happen. To enable staff to adjust to the new situation, what are the capacity building requirements required to:

- Support health workers
- Monitor and assess Internally displaced people
- Move towards humanitarian assistance integrating with local institutional capacity building.

**Conflict and health working *in* and *around* as well as *on* conflict**

The activity proposed would work within the proposed DFID peace building framework, which highlights the need; to place human rights at the front of the Aid agenda and to work on the oppression of women. There is opportunity to work *in* and *around* conflict as well as *on* conflict.

The focus will be to develop practicable activities;

- To enable the delivery of health services. Central to this are health workers, in particular those at the local level.
- To monitor the situation of internally displaced people.
- To prepare for humanitarian support if and when necessary

The following questions need to be addressed;

- What are the needs?
- How can they be addressed?
- Who can deliver?
- Clarity on the international law

- **Supporting health workers**

- Challenging and understanding health workers behaviour and its contribution to the conflict
- To adopt new practices...service delivery improved, corruption reduced, public/private issues
- To understand the legal responsibilities of and for health workers
- Negotiated operational boundaries with the security forces, first at national level then District level.
- To support local level health services and continue with development activities.

- **Internally displaced people** (at District level)

- Accessing and monitoring the situation
- Assessing public health needs
- Clarity on legal provisions
- Advocacy

- **Humanitarian supports**

- Monitoring the situation
- Identify timing when humanitarian response is necessary.
- Clarity on legal provisions
- Identifying locally appropriate service delivery options. Supporting local organisations developing their capacities to deliver humanitarian supports.
- Preparing project/programme staff to adopt different ways of working to move from development activities into humanitarian support.

To work on conflict and health issues will require different and new relationships e.g. linking and co-ordinating development, diplomatic and humanitarian activities, liaison with the security forces, and reality orientation with the government.

## **Basic tasks**

### ***First week***

- Reviewing existing reports and literature on the conflict
- Round table discussion with DFID, GTZ and SDC personnel to clarify TORs, and develop ideas
- Visit one/two districts to meet government, non government and project personnel; to test check issues on information collection

***Second week***

- Consultations with EDP personnel (Kathmandu and district based) to clarify findings, and to test check ideas; individual meetings and workshops
- Researching legal position of health workers in Nepal, in relation to international law
- Visiting key stakeholders in Kathmandu (DFID/GTZ/SDC advisers, ICRC, WFP etc)

The judicial system has three tiers: the Supreme Court, the Appellate Courts and the District Courts. The Constitution provides for an independent judiciary. In theory at least the upper Courts have demonstrated some independence but the legal system as a whole is marked by a general malaise of delay and prevarication in relation to fundamental issues affecting human rights. The legal profession for its part, and with notable exceptions, appears covered by widespread intimidation and arrests of lawyers<sup>18</sup> and unable to raise its integrity to command respect and confidence from the judiciary and the public at large. Certain lawyers have demonstrated exceptional courage and high professional ideals and ethics. But within the ambience of a civil society which is primarily based in Kathmandu and unable to maintain relationships with rural communities nor come to terms with the conflict in the rural areas and accommodate the democratic rule of law they alone cannot provide the necessary bulwark for the protection of health workers rights.

All in all the justice system is ill-equipped to deal with the human rights abuses reported by human rights workers, NGO's and international organisations during the escalation of the conflict. Put simply, in the context of affording effective protection against abuses and judicial remedies against arbitrary arrest and other actions, the legal system cannot be relied upon and there is a widespread lack of confidence in it.

At a formal and policy level the Nepalese Government respects its citizen's rights but, despite constitutional guarantees, human rights abuses continue to occur. There has been a deterioration in the level and type of abuses as a result of the Army's involvement. Complaints of abuses perpetrated by the Police and Armed Police continue unabated. Underdeveloped laws and a lack of sanction and accountability are the main contributing factors to the inability of Government to control these abuses.

The National Human Rights Commission was set up in 2000. It numbers eminent human rights activists among its membership. Regrettably there is little confidence for the time being that it is able to conduct its work efficiently and with sufficient clarity of purpose. Its track record to date of taking up complaints and pursuing them through the courts remains under close scrutiny. A newly formed coordination committee with representatives from all organs including the security forces provides some hope that prevalent and important matters and issues affecting human rights abuses can be put on the Commission's agenda more efficiently.

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<sup>18</sup> See Report of the International Bar Association, Nepal in Crisis: Justice caught in the cross-fire, September 2002

The State of Emergency was declared in November 2001 and lapsed on the 28<sup>th</sup> August 2002. It brought the Royal Nepal Army into the conflict for the first time. The Army has entered the arena of conflict with little assistance from the government and with a limited understanding of its role in civil society. The Army too is reported as being responsible for widespread perpetration of human rights abuses. It has little experience of dealing with such allegations and not being subject to judicial scrutiny, government control or democratic accountability it is totally unable to monitor or control its own excesses. The Army recently announced the setting up of a Human Rights Cell to deal with complaints of abuses. The population at large has greeted the news with considerable scepticism. Unless and until there is tangible evidence that the Army is able to regulate itself by being able to conduct proper enquiries, prosecutions and court-martials and punish those found guilty of abuses (and not only the rank and file but senior officers too) the concept will be doomed to fail.

Maoist intervention in the field of law is a relatively unknown factor. Reports of “peoples courts” and the like do not inspire confidence that any form of legal structure is in place nor that it is the intention of the disparate groups involved in the conflict under the Maoist banner to conform with universally accepted international norms on the rule of law. That being so, the Maoist movement proclaims nonetheless, through its political movement and affiliates that it is striving, Inter alia, for a “Free and scientific health services .. (which) should be managed for all” (Maoist 40 point demands 1996). More recently in the published agenda presented by the CPN (Maoist) for talks with the government (dated 13<sup>th</sup> September 2002) specific reference was made to “Health treatment should be considered fundamental right of the people and health services should be free and easily accessible to the people. Special emphasis should be given on expanding health services in rural areas.” Although these do not amount to any firm statement of intent or enforceable in any conceivable way they are worth noting as potential foundation stones in the event of any potential dialogue which may be pursued under one or other of the strategies which might be developed as a result of recommendations made herein.

### **International Humanitarian Law and human rights law**

It must be common ground that the role of the health worker in any conflict situation is considered to be a humanitarian function. As such international humanitarian law can intervene to protect the individual in a complementary manner to the protections afforded by human rights law. Each body of jurisprudence seeks to protect the individual in different circumstances and in different ways. So, whereas remedies for protecting human rights are expected to be found in the domestic legal framework, breaches of humanitarian law permit international intervention at the highest level – and in the last decade or so three international tribunals have been established to try persons accused of violations of international law including humanitarian law.

Humanitarian law applies in situations of conflict. Human rights protect individuals at all times. But given that States confronted by a serious public threat are legally able to derogate from treaty obligations and suspend the rights enshrined by them (save those considered to be fundamental) the complimentary role of humanitarian law comes into play. The purpose of humanitarian law is to protect victims by limiting the suffering caused by conflict. It does not seek to limit the power of a State over individuals.

Since humanitarian law applies precisely to the situations of armed conflict the fundamental rights that States must respect in all circumstances meld with the fundamental and legal guarantees provided by humanitarian law. In controlling its implementation there is an emphasis on cooperation between the parties to the conflict and a neutral intermediary with a view to preventing violations. The future, however, envisages a more robust approach with the setting up of the permanent International Criminal Court under the Treaty of Rome to try those perpetrating abuses of fundamental humanitarian guarantees.

### **Legal Framework**

Legal protection of health workers in this conflict situation derives from the legal framework, which imposes statutory professional obligations on Health Workers and International Treaty obligations as incorporated into the law of Nepal by the statutory provisions.

### **Health Professional Council Act (1996)**

**Section 2 (4)** : 'Health Profession' means treatment, diagnosis and prevention of patient's diseases and any other activities related to health profession.

**Section 4 (5)**: 'Health Professional' means person involved in health profession acquiring required minimum qualification.

**Section 18** : *Deletion of name from Register Book and re-registration:*

(1) The Health Professional Council shall give order to delete the name of the registered health professionals from the Register Book on any of the following circumstances:

(a) If he/ she is punished under the prevailing law on a criminal charge involving moral turpitude.

(b) *If the Council decides with two third majority for not fulfilling the prescribed professional ethics related to profession.*

- (c) If he/ she becomes insane or incapable to involve in the profession because of physical condition.

### **Health Professional Council Rule (1999)**

**Rule 2 (e)** 'Health Institution' means the Hospital or Nursing home or Primary Health Centre or Health Post or Sub-Health Post or any other Medical Institutions operated in any name at National or International, Governmental or Non-Governmental or in private sector.

**Rule 3:** The classification of Health Professionals and minimum qualification for the registration:

(1) Health Professionals have been classified on the following categories:

- (a) The first category
- (b) The second category
- (c) The third category

(2) To be registered as health professional under sub rule (1), concerned health professional requires to obtain following academic qualification or degree or training from the educational institution recognised by the council.

- (a) Minimum bachelor degree or equivalent on related subject for the first category.
- (b) Minimum intermediate level or equivalent on related subject for second category.
- (c) Minimum one academic years training on related subject for the third category.

### **Rule 13 : Professional Ethics**

(1) For the purpose of section 18 (1) (b) of the Act, the registered health professional shall have to follow the following professional ethics in course of their profession.

- (a) *Discipline and honesty.* The health profession shall be carried out with discipline and honesty.
- (b) *Be polite and maintain secrecy:* Medical professional shall be polite in dealing with the people, while carrying out their profession. They should not disclose the fact regarding health and private life of the patient elsewhere other than required by the prevailing law.

- (c) *Non discrimination*: The health professional should not discriminate against any person while applying personal knowledge and skill on the grounds of religion, race, sex and case or any other grounds.

**Commentary:**

The Act defines health workers or health professionals as those who, having acquired a defined or required minimum period of study or training, are registered with the Health Professional Council. By this definition the Act recognises all those who are involved and have the appropriate registration capacity. Non-medical workers, peons and other administrative staff, involved in the provision of health services are not recognised.

The Health Professional Council Rules are incorporated into the Act. Of particular relevance are the rules cited above and dealing with training requirements and professional ethics and obligations respectively.

Rule 13(c) requires health professionals at all times to provide treatment without discrimination “on the grounds of religion, race, gender or any other ground. It is an unqualified obligation.

Rule 13(b) obliges health professionals to maintain confidentiality of the patient in terms of “personal life and medical history” *unless required by law*. The qualification in italics may give some cause for legal discussion in the context of anti-terrorist and anti-insurgency legislation (see below) but legal researches have revealed no provision in any legislation, save for the provisions of the Civil Code discussed below, which requires, in certain circumstances health workers to divulge confidences of the patient being treated. At common law (and in the interpretation of the law in Nepal consideration is often given to common law jurisprudence) the concept of the professional obligation of confidentiality is well developed. Confidence is not absolute and disclosure may be justified in the public interest, where there is a statutory duty to disclose information or on the orders of the court (in England only lawyers are protected by privilege against disclosure). The public interest is very narrowly defined and involves a weighing exercise conducted by the courts where the public interest in maintaining confidentiality is balanced against the merits of access to particular information.

In Nepal there is no law which proscribes such a duty of medical confidentiality. Furthermore, on the basis of the established common law principles, such disclosure can only be ordered through a judicial process on a case-by-case basis.

## Civil Code

A common misconception which appears to have surfaced is that the Civil Code requires all health workers to divulge to the authorities the details of patients treated for wounds which may have been inflicted by an unlawful assault or other form of violence.

Section 20 of the Code does indeed allow professionals involved in medical treatment of a patient to notify the authorities of such an incident but it is a provision aimed at allowing and facilitating the victim of a crime to report it to the authorities through medical channels. In no way does the Code envisage such reports being made or required to be made against the wishes of patients.

## Terrorist and Destructive Acts (Control and Punishment ) Act 2002.

**Section 2 (g):** Terrorist and Destructive acts mean the terrorist and destructive acts mentioned in section 3:

**Section 2 (h):** Accomplice means the following person:

**Section 2 (h) (3):** Any person, who intentionally provides direct or indirect support by providing financial, physical and shelter to any person or group engaged in terrorist and destructive acts, except forced to do so.

## Commentary:

The aim of the act, as the name suggest, is to control and punish acts of terrorism and other destructive activities. The impetus for the TADA was the activities of the Maoist groups in Nepal. Health workers, caught in the crossfire of the conflict, are most at risk of the incorrect and inappropriate interpretation of the provisions of this Act by the security forces. The consequences for Health Workers are evidenced in the fact-finding chapter of this report.

A terrorist and destructive crime is defined in section 3 of the Act as any activity against the sovereignty, integrity, peace and security of Nepal through intentional disturbance or damage to property, lives or health using weapons, bombs, or explosive substances or poisons. It is also an offence to threaten to do any of these things, produce or distribute weapons and items described above, or to train people in these activities, collect or loot cash goods or property for the purposes. A person is deemed to have committed these offences if they attempt or conspire to do so, or encourage others to do so.

Section 5 allows the Government or any security officer (police or army) to arrest anyone *sufficiently and reasonably* believed to be involved in terrorist and disruptive activities. Wide powers of search and seizure follow. Any person

intentionally disrupting searches or taking steps to prevent such activity can be arrested and charged under the Act.

Section 2(3) contains an important deeming provision in relation to support and encouragement of terrorist activity. A person provides such support if they provide direct or indirect support “such as financial, physical, and shelter, unless compelled..... “ Two points to note: the deeming provisions specifically exclude providing medical treatment as one of the support for terrorist activities which will be considered criminal under this act. Secondly, the deeming provision is heavily qualified by the issue of being compelled to provide such support. In our view and from an evidential point of view the burden of proving the absence of compellability remains firmly on the accuser there being no reversal of burden in this section of the Act.

The power of preventative detention under section 9 of the Act allows a person to be detained for up to 90 days to prevent that person from doing anything that causes terrorist or destructive activities.

The Act envisages the setting up of a “Follow-Up and Co-ordination Committee” to consider complaints by persons aggrieved by the conduct of the security forces. The committee is empowered to make its own investigations and procedures and can make suggestions to government. Its decisions are not binding. To date no chair has been appointed.

It is arguable that TADA is technically compliant with Nepal’s constitution, which requires that all laws inconsistent with it are void. But in its applicability there can be little doubt that it infringes many of the constitutional protections of fundamental rights. Of particular note is the purported suspension of habeas corpus and breaches of non-derogable fundamental rights such as those relating to criminal justice covered by Article 14 of the Constitution: torture or cruel inhuman or degrading treatment shall not be inflicted on detainees. Article 14 also provides that a detainee will be informed as soon as possible of grounds of arrest and allowed to consult a lawyer. To cite but one example of these breaches discovered during the fact finding phase: it is not uncommon for the security forces to detain a person, incommunicado, to determine whether there might be some substance to their suspicions that the health worker may have information as to Maoist movements (a classic “fishing expedition”).

### **Treaty Act 1990**

The Act incorporates into the law of Nepal international conventions and obligations. Section 9 provides that once ratification has occurred the provisions of any laws that conflict with the treaty are invalid to the extent of such conflict and the provisions of the treaty shall be applicable as Nepalese laws.

Of particular relevance to the situation affecting health workers are the provisions of the Geneva Conventions of 1949 on the conduct of armed conflict having acceded to them on 7<sup>th</sup> February 1964. Common Article 3 of these conventions provides that in an armed conflict not of an international character persons taking no part in the hostilities are to be treated humanely.

The Protocols Additional to the Geneva Conventions relating to the protection of victims of international armed conflicts and victims of non-international armed conflicts have not been formally adopted by Nepal 25 years on from the Diplomatic Conference in 1977. The Second Additional Protocol in particular is of relevance since it deals specifically with the protection of the individual in non-international conflicts. Even so, and notwithstanding express ratification, the whole basis of humanitarian law contained in these protocols is that it lays down minimum standards of acceptable conduct. It is benchmark against which future legal action may be taken against States and individuals on the ground.

**Job descriptions for health workers****Appendix 3**

A “health professional” is a person who is involved in the treatment, diagnosis, and prevention of disease and any other activity related to the health profession (Health Professional Council Act 1996). For the purposes of this report “health workers” is the term of reference used to describe all those involved in the provision of health services including support and administrative personnel.

The peons being local and often the most consistently present employees, actually provide treatment but are not legally protected, as they are not officially considered to be health workers.

<b>S #</b>	<b>Job title</b>	<b>Main Responsibility</b>
1.	DHO (District Health Office Chief)	Chief of entire district health program in planning, public health, hospital, administration, program review, reporting, co-ordination and others as per need.
2.	DPHO (District Public Health Officer)	preparation of all districts health plan, implementation, co-ordination, monitoring and evaluation of the program and supervision all district health staff including volunteers.
3.	PHO (Public Health Officer)	district planning, implementation, co-ordination, supervision and monitoring and evaluation of the preventive, promotive and curatives program under the direction of DHO.
4.	SPHN (Senior Public Health Nurse)	delivering the district safer motherhood program, immunization, nutrition and community health nursing services (environment, epidemic, FCHVs, TBAs , health education, ORC (Out Reach Clinic) training) including reporting, co-ordination and supervision.
5.	PHN (Public Health Nurse)	Delivery of the safer motherhood program, immunization, nutrition, family planning including MIS, co-ordination and supervision at her working areas in the district.
6.	DA (District Assistant) HEA-technician (Health Education Assistant)	all planning and evaluation of the training program including IEC (Information Education and Communication) activities.

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7.	HA/SAHW (Health Assistant/ Senior Auxiliary Health Worker)	CDD, ARI, Epidemic and communicable disease control program on the direction of DHO/DPHO.
8.	DSA (District Statistic Assistant)	recording of information, review and feedback and reporting with co-ordination in the concerned section head.
9.	FPA (Family Planning Assistance)	Family Planning program in the district`.
10.	DIS (District Immunization Supervisor)	Immunization program in the district.
11.	CCA (Cold Chain Maintain)	cold-chain room, vaccine supply, maintenance of freeze, refrigerator, defreeze, cold box and ice pack.
12.	DTLA (District Tuberculosis and Leprosy Assistant)	helping the staff of PHC/HP/SHP to deliver the Tuberculosis and Leprosy Control program.
13.	VCA (Vector Control Assistant)	management of vector born diseases controlling in the district.
14.	MI (Malaria Inspector)	assists the VCA (Vector Control Assistant) in order to manage the control of vector born diseases.
15.	LT (Lab Technician)	the District Health Laboratory Services.
16.	LA (Lab Assistant)	assists the LT (Lab Technician) to provide the laboratory services.
17.	AO (Admin Officer)	all district administrative work of D(P)HO in co-ordination with Regional Director.
18.	Accountant	financial management and preparing all necessary documents for audit.
19.	AA (Admin Assistant)	daily administration, logistic, personal files maintain in consultation with D(P)HO and administrative officer.
20.	Typist (Kharidar)	All typing of the D(P)HO.

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21 .	Store Keeper (Kharidar)	store management in district.
		<b>At PHC level</b>
22 .	PHCI (Primary Health Care In-charge)	the entire program, administration, recording, reporting and other support of Primary Health Care Centre.
23 .	SN (Staff Nurse)	planning and implementation of FP, SMH including inpatient delivery cases, recording and reporting, training, follow-up of and supervision of ANM.
24 .	HA/SAHW (Health Assistant/Senior Auxiliary Health Worker)	planning of Immunization, CDD, ARI, Nutrition, TB, Leprosy, AIDS/STD, and supervision and monitoring of the program.
25 .	AHW (Auxiliary Health Worker)	health services delivery of the PHC.
26 .	ANM (Auxiliary Nurse Midwife)	providing the reproductive, children program and other services as per need.
27 .	LA (Lab Assistant)	provision of lab services at PHC.
28 .	SA (Sub Accountant)	administrative work, finance, store and safety of the PHC.
29 .	Peon	daily cleanliness of all rooms and bathroom, gardening, waste products disposal, messenger's work and follows others order.
		<b>At HP level</b>
30 .	HPI (Health Post In-charge)	the entire program, administration, record report of the health post.
31 .	AHW (Auxiliary Health Worker)	health services delivery of concerned HP.
32 .	ANM (Auxiliary Nurse Midwife)	providing the reproductive program, immunization and necessary services.
33 .	VHW (Village Health Worker)	ORCC, Immunization clinic, and linkage with the concerned people.
34 .	Mukhiya	administration, finances, and store of the Health Post.

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		<b><i>At SHP level</i></b>
35 .	SHPI (Sub Health Post In-charge)	the entire program, administration, recording and reporting of the sub health post.
36 .	VHW (Village Health Worker)	preparing schedule of ORC and Immunization clinic, education on STD, nutrition, CDD, ARI and report collection from FCHV/TBAs.
37 .	MCHW (Maternal and Child Health Worker)	scheduling of ORC, Immunization clinic and mothers group with the VHW, provides education on FP, Malnutrition, communicable diseases, meeting with FCHVs and TBAs, reporting and recording.
38 .	Peon	cleanliness, gardening, waste products disposal, messenger's work and follows others order.
	<b>VOLUNTEERS</b>	
39 .	Female Community Health Volunteer (FCHV)	Health education through the mothers groups; leads mothers groups
40 .	Traditional Birth Attendants (TBA)	Conducting home delivery and education to ante-natal and post natal mothers groups (house to house)